ForwardHealth
Wisconsin serving you

Update
June 2008

No. 2008-52

Affected Programs: BadgerCare Plus, Medicaid
To: Outpatient Mental Health Clinics, Psychotherapists, HMOs and Other Managed Care Programs

Changes to Prior Authorization for HealthCheck "Other Services" In-Home Mental Health and Substance Abuse Treatment Services for Children

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for in-home mental health and substance abuse treatment services for children, effective October 2008, with the implementation of the ForwardHealth interChange system. These changes include the following:

- Establishing deadlines for providers to respond to returned PA requests and PA amendment requests.
- Revising all PA forms. The following PA forms will be available to download and print from the Web at *dhfs.wisconsin.gov/ForwardHealth/*:
  - ✓ Prior Authorization Request Form (PA/RF), F-11018 (10/08).
  - ✓ Prior Authorization Amendment Request, F-11042 (10/08).
  - ✓ Prior Authorization/In-Home Treatment Attachment (PA/ITA), F-11036 (10/08).
  - ✓ Model Plan: In-Home Mental Health/Substance Abuse Treatment Services, F-11105 (10/08).
  - ✓ Model Multi-Agency Treatment Plan, F-11106 (10/08).

  Providers may also order copies from Provider Services.

The changes were made to do the following:

- Provide efficiencies for both providers and ForwardHealth.
- Accommodate changes required for full National Provider Identifier implementation.
- Align with Health Insurance Portability and
- Accountability Act of 1996 (HIPAA) terminology.

A separate *Update* will give providers a calendar of additional important dates related to implementation including when to begin submitting the revised PA forms. Information in this *Update* applies to providers who provide services for BadgerCare Plus Standard Plan and Wisconsin Medicaid members.

Changes to Prior Authorization with the Implementation of ForwardHealth interChange

In October 2008, the Department of Health and Family Services (DHFS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to PA forms and procedures that are detailed in this *Update*. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements). The changes were made to:

- Provide efficiencies for both providers and ForwardHealth. Providers will be able to submit PA requests and receive decisions and requests for additional information via the ForwardHealth Portal.
- Accommodate changes required for full National Provider Identifier (NPI) implementation. Prior authorization forms were revised to include elements for providers to indicate NPI and taxonomy information.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

Note: Specific implementation dates will be published in a separate *Update*. Use of information presented in this *Update* prior to implementation may result in returned PA requests.

Information in this *Update* applies to providers who provide services for BadgerCare Plus Standard Plan and Wisconsin Medicaid members.

Submitting Prior Authorization Requests

Using the ForwardHealth Portal, providers will be able to submit PA requests for *all* services requiring PA. In addition to the Portal, providers may submit PA requests via any of the following:

- Fax at (608) 221-8616.
- Mail to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  6406 Bridge Rd
  Madison WI 53784-0088

Watch for future publications for information on submitting PA requests via the Portal.

Prior Authorization Numbers

The PA number will no longer be pre-printed on the Prior Authorization Request Form (PA/RF), F-11018 (10/08). As a result, providers will be able to download and print the form from the Portal and no longer have to order pre-printed forms from ForwardHealth. Upon receipt of the form, ForwardHealth will assign a PA number to each PA request.

The PA number will consist of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request). Refer to Attachment 1 of this *Update* for information about interpreting PA numbers.

Changes to Prior Authorization Forms

With the implementation of ForwardHealth interChange, in-home mental health and substance abuse treatment services for children providers submitting a paper PA request will be required to use the revised PA/RF. Refer to Attachments 2 and 3 for completion instructions and a copy of the PA/RF for providers to photocopy. Attachment 4 is a sample PA/RF for in-home mental health and substance abuse treatment services for children.

Note: If ForwardHealth receives a PA request on a previous version of the PA/RF, a letter will be sent to the provider stating that the provider is required to submit a new PA request using the proper forms. This may result in a later grant date if the PA request is approved.

Revisions to the Prior Authorization Request Form and Instructions

The following revisions have been made to the PA/RF:

- The PA number is eliminated from the form.
- The paper PA/RF is a one-part form (no longer a two-part, carbonless form) that can be downloaded and printed. The PA/RF is available in two formats on the Portal — Microsoft® Word and Portable Document Format (PDF).
- Checkboxes are added for HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP) (Element 1) to create efficiencies for providers who render services to members in Wisconsin Medicaid, BadgerCare Plus, and WCDP.
- The term "rendering provider" replaces "performing provider" to align with HIPAA terminology.
- Billing and rendering provider taxonomy code fields are added (Elements 5b and 17) to accommodate NPI implementation.
- In the billing provider's name and address fields, providers are now required to include the ZIP+4 code (Element 4) to accommodate NPI implementation.

Prior Authorization Attachments

With the implementation of ForwardHealth interChange, in-home mental health and substance abuse treatment services for children providers submitting a paper PA request will be required to use the revised Prior Authorization/In-Home Treatment Attachment (PA/ITA), F-11036 (10/08); Model Plan: In-Home Mental Health/Substance Abuse Treatment Services, F-11105 (10/08); and Model Multi-Agency Treatment Plan, F-11106 (10/08). While the basic information requested on the forms has not changed, the format of the forms has changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests. Refer to Attachment 7 for a copy of the completion instructions for the PA/ITA. Attachment 8 is a copy of the PA/ITA for providers to photocopy. Attachment 9 is a copy of the Model Plan: In-Home Mental Health/Substance Abuse Treatment Services and Attachment 10 is a copy of the Model Multi-Agency Treatment Plan for providers to photocopy.

Obtaining Prior Authorization Request Forms and Attachments

The PA/RF, PA/ITA, Model Plan: In-Home Mental Health/Substance Abuse Treatment Services, and Model Multi-Agency Treatment Plan are available in fillable PDF or fillable Microsoft® Word from the Forms page at *dhfs.wisconsin.gov/ForwardHealth/* prior to implementation and will be available from the Portal after implementation.

The fillable PDF is accessible using Adobe Reader® and may be completed electronically. To use the fillable PDF, click on the dash-outlined boxes and enter the information. Press the "Tab" key to move from one box to the next.

To request a paper copy of the PA/RF, PA/ITA, Model Plan: In-Home Mental Health/Substance Abuse Treatment Services, or Model Multi-Agency Treatment Plan for photocopying, call Provider Services at (800) 947-9627. Questions about the forms may also be directed to Provider Services.

In addition, a copy of any PA form and/or attachment is available by writing to ForwardHealth. Include a return address, the name of the form, and the number of the form (if applicable) and mail the request to the following address:

ForwardHealth
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Prior Authorization Decisions

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved as requested.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The new decision notice letter or returned provider review letter implemented with ForwardHealth interChange will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), not to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth.

Providers can also correct PAs that have been placed in returned provider review status in the Portal.

The provider's paper documents submitted with the PA request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the Portal. If the provider's response is received within 30 calendar days, ForwardHealth will still consider the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This will result in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through the WiCall Automated Voice Response system. Watch for future publications for more information regarding checking PA status via WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

New Amendment Process

Providers are required to use the Prior Authorization Amendment Request, F-11042 (10/08), to amend an approved or modified PA request. The Prior Authorization Amendment Request was revised to accommodate NPI information.

Instructions for completion of the Prior Authorization Amendment Request are located in Attachment 5. Attachment 6 is a copy of the revised Prior Authorization Amendment Request for providers to photocopy.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), not to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Valid Diagnosis Codes Required

Effective with implementation, the PA/RF will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific, diagnosis codes may have up to five digits.

Prior authorization requests sent by mail or fax with an invalid diagnosis code will be returned to the provider. Providers using the Portal will receive a message that the diagnosis code is invalid and will be allowed to correct the code and submit the PA request.

Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health and Family Services (DHFS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHFS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *dhfs.wisconsin.gov/forwardhealth/*.

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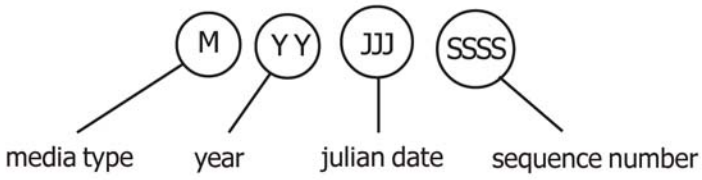
ATTACHMENT 1
Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.



Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Digits are identified as follows: 1= paper; 2 = fax; 3 = Specialized Transmission Approval Technology-Prior Authorization (STAT-PA); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = National Council for Prescription Drug Programs (NCPDP) transaction
Year — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

ATTACHMENT 2
Prior Authorization Request Form (PA/RF) Completion Instructions for In-Home Mental Health and Substance Abuse Treatment Services for Children

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the Prior Authorization/In-Home Treatment Attachment (PA/ITA), F-11036, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck "Other Services." Enter an "X" in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter process type "126" — Psychotherapy.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and the four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct number.

Element 7 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 10 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests. The maximum backdating allowed is 10 working days from the date of receipt at Wisconsin Medicaid.

Element 16 — Rendering Provider Number
Enter the NPI of the certified psychotherapist/substance abuse counselor.

Element 17 — Rendering Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code of the certified psychotherapist/substance abuse counselor.

Element 18 — Procedure Code
Enter the appropriate procedure code for each service requested.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

Element 20 — POS
Enter the appropriate place of service (POS) code designating where the requested service would be provided.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate procedure code for services.

Element 22 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

Element 24 — Total Charges
Enter the anticipated total charges for this request.

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

ATTACHMENT 3
Prior Authorization Request Form (PA/RF)
(for photocopying)

(A copy of the "Prior Authorization Request Form [PA/RF]" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable ❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	2. Process Type	3. Telephone Number — Billing Provider
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)		5a. Billing Provider Number 5b. Billing Provider Taxonomy Code

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
9. Name — Member (Last, First, Middle Initial)	10. Gender — Member ❑ Male ❑ Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date	

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	

25. **SIGNATURE** — Requesting Provider	26. Date Signed

DT-PA049-049

ATTACHMENT 4
Sample Prior Authorization Form (PA/RF) for In-Home Mental Health and Substance Abuse Treatment Services for Children

(The sample "Prior Authorization Request Form [PA/RF]" for in-home mental health and substance abuse treatment services for children is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
☒ HealthCheck "Other Services" ☐ Wisconsin Chronic Disease Program (WCDP)	**126**	**(555) 555-5555**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0123456780**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
Member, Im A.	☐ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
313.81 — oppositional defiant disorder		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
	MM/DD/CCYY

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
9876543210	**012345678X**	**H0004**	**HA**	**HO**			**12**	**Behavioral health counseling and therapy, per 15 minutes**	**104**	**XXX.XX**
9876543210	**012345678X**	**H0004**	**HA**	**HN**			**12**	**Behavioral health counseling and therapy, per 15 minutes**	**208**	**XXX.XX**
9876543210	**012345678X**	**99082**	**HA**	**HO**			**99**	**travel**	**13**	**XXX.XX**
9876543210	**012345678X**	**99082**	**HA**	**HN**			**99**	**travel**	**26**	**XXX.XX**

Sample Prior Authorization Request Form [PA/RF] for In-Home Mental Health and Substance Abuse Treatment Services for Children

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BaderCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	**XXX.XX**

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	**MM/DD/CCYY**

ATTACHMENT 5
Prior Authorization Amendment Request Completion Instructions

(A copy of the "Prior Authorization Amendment Request Completion Instructions" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers are required to use the Prior Authorization Amendment Request, F-11042, to request an amendment to a PA. The use of this form is mandatory when requesting an amendment to a PA. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the PA Decision Notice of the PA to be amended along with physician's orders, if applicable, (within 90 days of the dated signature) and send it to ForwardHealth. Providers may submit the Prior Authorization Amendment Request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER INFORMATION

Element 1 — Original PA Number
Enter the unique PA number from the original PA to be amended.

Element 2 — Process Type
Enter the process type as indicated on the PA to be amended.

Element 3 — Member Identification Number
Enter the member ID as indicated on the PA to be amended.

Element 4 — Name — Member
Enter the name of the member as indicated on the PA to be amended.

SECTION II — PROVIDER INFORMATION

Element 5 — Billing Provider Number
Enter the billing provider number as indicated on the PA to be amended.

Element 6 — Name — Billing Provider
Enter the name of the billing provider as indicated on the PA to be amended.

SECTION III — AMENDMENT INFORMATION

Element 7 — Address — Billing Provider
Enter the address of the billing provider (include street, city, state, and ZIP+4 code) as indicated on the PA to be amended.

Element 8 — Requested Start Date
Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

Element 9 — Requested End Date (If Different from Expiration Date of Current PA)
Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different that the current expiration date.

Element 10 — Reasons for Amendment Request
Enter an "X" in the box next to each reason for the amendment request. Check all that apply.

Element 11 — Description and Justification for Requested Change
Enter the specifics and supporting rationale of the amendment request related to each reason indicated in Element 10.

Element 12 — Are Attachments Included?
Enter an "X" in the appropriate box to indicate if attachments are or are not included with the amendment request. If Yes, specify all attachments that are included.

Element 13 — Signature — Requesting Provider
Enter the signature of the provider that requested the original PA.

Element 14 — Date Signed — Requesting Provider
Enter the date the amendment request was signed by the requesting provider in MM/DD/CCYY format.

ATTACHMENT 6
Prior Authorization Amendment Request (for photocopying)

(A copy of the "Prior Authorization Amendment Request" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11042 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

SECTION I — MEMBER INFORMATION

1. Original PA Number	2. Process Type	3. Member Identification Number

4. Name — Member (Last, First, Middle Initial)

SECTION II — PROVIDER INFORMATION

5. Billing Provider Number	7. Address — Billing Provider (Street, City, State, ZIP+4 Code)
6. Name — Billing Provider	

SECTION III — AMENDMENT INFORMATION

8. Requested Start Date	9. Requested End Date (If Different from Expiration Date of Current PA)

10. Reasons for Amendment Request (Check All That Apply)

- ❑ Change Billing Provider Number
- ❑ Add Procedure Code / Modifier
- ❑ Change Procedure Code / Modifier
- ❑ Change Diagnosis Code
- ❑ Change Grant or Expiration Date
- ❑ Discontinue PA
- ❑ Change Quantity
- ❑ Other (Specify)_____

11. Description and Justification for Requested Change

12. Are Attachments Included? ❑ Yes ❑ No
If Yes, specify attachments below.

13. **SIGNATURE** — Requesting Provider	14. Date Signed — Requesting Provider

ATTACHMENT 7
Prior Authorization/In-Home Treatment Attachment (PA/ITA) Completion Instructions

(A copy of the "Prior Authorization/In-Home Treatment Attachment [PA/ITA] Completion Instructions" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION / IN-HOME TREATMENT ATTACHMENT (PA/ITA) COMPLETION INSTRUCTIONS

ForwardHealth require certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory to receive PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/In-Home Treatment Attachment (PA/ITA), F-11036, to the Prior Authorization Request Form (PA/RF), F-11018, a physician prescription, and HealthCheck screen documentation dated within 365 days prior to the grant date being requested and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

GENERAL INSTRUCTIONS

The information contained on this PA/ITA will be used to make a decision about the amount of intensive in-home treatment that will be approved for ForwardHealth reimbursement. Complete each section as thoroughly as possible. Where noted in these instructions, the provider may attach material from his or her records.

Initial Prior Authorization Request

Complete the PA/RF and the entire PA/ITA. The initial authorization will be for a period of no longer than 13 weeks. Attach a copy of the HealthCheck verification and physician order dated not more than one year prior to the requested first date of service (DOS).

First Reauthorization

Complete the PA/RF and Sections I-III of the PA/ITA. Attach a copy of the HealthCheck verification and physician order dated not more than one year prior to the requested first DOS. (As long as the HealthCheck verification and physician order submitted in the initial request are timely, they may be used for subsequent requests.) Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan. Authorization may be granted for up to 13 weeks.

Subsequent Reauthorizations

Complete the PA/RF and Sections I-III of the PA/ITA. Attach a copy of the HealthCheck verification and physician order dated not more than one year prior to the requested first DOS. (As long as the HealthCheck verification and the physician order submitted in the initial request are timely, they may be used for subsequent requests.) Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan. Summarize the treatment since the previous authorization. The need for continued in-home treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of the in-home treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Discuss plans for terminating in-home treatment and the services that the recipient/family will require. Authorization will be for a period of no longer than 13 weeks.

Check the appropriate box at the top of the PA/ITA to indicate whether this request is an initial, first reauthorization, or subsequent reauthorization. Make sure that the appropriate materials are included for the type of request indicated.

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Member
Enter the age of the member in numerical form (e.g., 16, 21).

Element 3 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Medicaid-Certified Clinic
Enter the name of the Medicaid-certified psychotherapy/substance abuse clinic that will be billing for the services.

Element 5 — Clinic's National Provider Identifier (NPI)
Enter the National Provider Identifier (NPI) of the Medicaid-certified psychotherapy/substance abuse clinic that will be billing for the services.

Element 6 — Name — Rendering Psychotherapist/Substance Abuse Counselor
Enter the name of the Medicaid-certified psychotherapist/substance abuse counselor who will be the lead member of the team providing services. Master's-level psychotherapists must obtain a rendering provider NPI in order to bill for these services even if this is not ordinarily required for the type of facility by which they are employed.

Element 7 — Rendering Psychotherapist's or Substance Abuse Counselor's NPI
Enter the NPI of the certified psychotherapist/substance abuse counselor identified in Element 6.

Element 8 — Telephone Number — Psychotherapist/Substance Abuse Counselor
Enter the telephone number, including the area code, of the certified psychotherapist/substance abuse counselor identified in Element 6.

Element 9 — Discipline — Psychotherapist/Substance Abuse Counselor
Enter the discipline of the certified psychotherapist/substance abuse counselor identified in Element 6 (e.g., Ph.D.).

SECTION III

Element 10
Enter the requested start and end dates for this authorization period. The initial authorization may be backdated up to 10 working days prior to the receipt of the request at ForwardHealth if the provider requests backdating in writing and documents the clinical need for beginning services immediately. Note the guidelines for the length of authorizations under the "General Instructions" section of these instructions.

Element 11
Enter the total expected number of hours the family will receive direct treatment services over this PA grant period (e.g., the current 13-week period). When two therapists are present at the same time, this is still counted as one hour of treatment received by the family. Also indicate the anticipated pattern of treatment for each team member (e.g., a two-hour session once a week for 13 weeks by the certified psychotherapist, a two-hour session once a week for 13 weeks by the second team member with a certified therapist, plus a one-hour session twice a week for 13 weeks with the second team member independently). More than 104 hours of direct treatment to the family during a 13-week period will not be authorized.

Element 12
Indicate the number of hours that the certified psychotherapist/substance abuse counselor will provide direct treatment services to the family and the number of hours that the second team member will provide direct treatment to the family. If more than two providers will be involved in providing services, document that all individuals meet the criteria in these guidelines. Total hours of treatment must not exceed the limitation noted in Element 11. Reimbursement is not allowed for more than two providers for the same treatment session. Since two providers may be providing services at the same time on occasion, the total hours in this section may exceed the number of hours of treatment the family will receive as noted in Element 11. If the primary psychotherapist is involved in treatment more than 50 percent of the time (e.g., if the primary therapist's direct treatment hours exceed those of the second team member's), special justification should be noted on the request.

Indicate the name and qualifications of the second team member. Attach a résumé, if available. The minimal qualifications must be one of the following:

- An individual who possesses at least a Bachelor's degree in a behavioral science, a registered nurse, an occupational therapist, a Medicaid-certified substance abuse counselor, or a professional with equivalent training. The second team member must have at least 1,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.
- Other individuals who have had at least 2,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.

The second team member will be reimbursed at a lower rate, even if that person is a Medicaid-certified psychotherapist. The second team member works under the supervision of the certified psychotherapy provider.

If the second team member is a Medicaid-certified psychotherapy/substance abuse provider, indicate his or her qualifications by entering his or her rendering provider NPI.

Element 13
Indicate the travel time required to provide the service. Travel time should consist of the time to travel from the provider's office to the member's home or from the previous appointment to the member's home. Travel time exceeding one hour one-way will generally not be authorized.

SECTION IV

Element 14
Present a summary of the mental health assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders,* or for children to age four, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: 0-3,* are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defense functioning. The assessment summary should provide documentation supporting the diagnosis. A psychiatrist or psychologist must review and sign the summary and diagnosis indicating his or her agreement with the results. In those cases, where the only, or primary, diagnosis is a substance abuse disorder, requests will be approved only if there is sufficient justification for the services to be provided in the home, rather than in another setting. Providers may attach copies of an existing assessment if it is no longer than two pages.

Element 15
Present a summary of the member's illness, treatment, and medication history. In those cases where the member has spent significant amounts of time out of the home, or is out of the home at the time of the request, the treatment plan must specifically address the transition, reintegration, and attachment issues. For individuals with significant substance abuse problems, the multi-agency treatment plan must explain how these will be addressed. For individuals 16 years and over who have spent significant amounts of time out of the home, the request must discuss why intensive in-home treatment is preferred over preparing the member for independent living. Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.

Element 16
Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED).

a. List the primary diagnosis and diagnosis code in the space provided. Not all ForwardHealth-covered in-home mental health and substance abuse treatment services are appropriate or allowable. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as child/adolescent day treatment or in-home or outpatient mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation.
b. Complete the checklist to determine whether an individual would substantially meet the criteria for SED.
c. Check those boxes that apply. The individual must have one symptom or two functional impairments described as follows.

Symptoms

1. Psychotic symptoms — Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
2. Suicidality — The individual must have made one attempt within the last three months or have significant ideation about or have made a plan for suicide within the past month.
3. Violence — The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

Functional Impairments (Compared to Expected Developmental Level)

1. Functioning in self care — Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
2. Functioning in community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, judgment, and a value system that results in potential involvement or involvement in the juvenile justice system.
3. Functioning in social relationships — Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
4. Functioning in the family — Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness), inability to conform to reasonable limitations, and expectations that may result in removal from the family or its equivalent.
5. Functioning at school/work — Impairment in any one of the following:
   a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence towards others.
   b) Meeting the definition of "child with a disability" under ch. PI 11, Wis. Admin. Code, and s. 115.76, Wis. Stats.
   c) Impairment at work is the inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with supervisor and other workers, or hostile behavior on the job.
   d) The individual is receiving services from two or more of the following service systems:
      - Mental health.
      - Juvenile justice.
      - Social services.
      - Special education.
      - Child protective services.

Eligibility criteria are waived under the following circumstances:

- The member substantially meets the criteria for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning, but would likely do so without in-home mental health and substance abuse treatment services. Attach an explanation.
- The member substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

Element 17

Present an assessment of the family's strengths and weaknesses. Present evidence that the family is willing to be involved in treatment and is capable of benefiting from treatment. Where the presence of significant psychological dysfunctioning or substance abuse problems is indicated among family members, indicate on the multi-agency treatment plan how these problems will be addressed.

Element 18

The provider is required to specifically identify the rationale for providing services in the home for this child/family. A significant history of failed outpatient treatment along with documentation that identifies a significant risk of out-of-home placement will support such a request. Strong justification is needed if outpatient clinic services have not been previously attempted. The provider should identify specific barriers to the family receiving treatment in a clinic setting or specific advantages for this family receiving services in the home (not simply general advantages of in-home treatment). The provider should present this justification in his or her own words and not assume that the consultant can infer this from other information submitted with this request.

Element 19

Indicate the expected date of termination or expected duration of in-home treatment. Describe services expected to be needed following completion of in-home treatment and transition plans. While providers are expected to indicate their expectations on the initial requests, it is critical that plans for terminating in-home treatment be discussed in any authorizations for services at and beyond six months of treatment.

SECTION V

Element 20

The following materials must be attached and labeled:

a. The PA/RF may be obtained from ForwardHealth. Providers should use processing type "126" in Element 2. The "HealthCheck Other Services" should be marked in Element 1. Providers should use the appropriate procedure codes, modifiers, and descriptions in Elements 18, 19, and 21 of the PA/RF.

   The quantity requested in Element 22 of the PA/RF should represent the total hours for the grant period requested and Element 23 of the PA/RF should represent charges for all hours indicated in Element 22.

b. Attach a physician's prescription order for in-home treatment services dated not more than one year prior to the requested first DOS.

c. The request must include documentation that the recipient had a comprehensive HealthCheck screening within 365 days prior to the grant date being requested. This documentation must be one of the following:
   - Verification that a HealthCheck screen has been performed by a valid HealthCheck screener dated not more than one year prior to the requested first DOS.
   - A copy of the HealthCheck provider's billing form showing a claim for a comprehensive HealthCheck screening.
   - A copy of the HealthCheck provider's Remittance Advice showing a claim for a comprehensive HealthCheck screening.
   - A HealthCheck referral from the HealthCheck provider.
   - A letter on the HealthCheck provider's letterhead indicating the date on which they performed a comprehensive HealthCheck screening of the recipient.

d. The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist. The plan must address the role of each system in the overall treatment and the major goals for each agency involved. The plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider is required to document the reason and what attempts were made to include them. The plan should indicate why services in the home are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist or psychologist is required to sign either the multi-agency plan or in-home treatment plan. If the child is prescribed psychoactive medication, the prescriber is required to be identified in the multi-agency treatment plan. Providers may use the Model Multi-Agency Treatment Plan, F-11106.

   If a multi-agency plan other than the model plan is used, all information on the model plan must be included.

e. The in-home treatment team is required to complete a treatment plan covering their services. A psychiatrist or psychologist is required to sign either the in-home treatment plan or the multi-agency treatment plan. The Model Plan: In-Home Mental Health/Substance Abuse Treatment Services, F-11105, may be used for this purpose. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The methods must allow for a clear determination that the services provided meet criteria for ForwardHealth-covered services. Services that are primarily social or recreational in nature are not reimbursable. The plan should clearly identify which team members are providing the ForwardHealth-covered services being requested.

   Services provided to the member's parents, foster parents, siblings, or other individuals significantly involved with the member are deemed appropriate as part of the in-home treatment plan when these services are required to directly affect the member's functioning at home or in the community. Such services include family therapy necessary to deal with issues of family dysfunctioning, behavior training with responsible adults to identify problem behaviors and develop appropriate responses, supervision of the child and family members in the home setting to evaluate the effect of behavioral intervention approaches and provide feedback to the family on implementing these interventions, and minimal supportive interventions with the family members to ensure their continued participation in the in-home treatment process. Interventions with family members or significant others that are primarily for the benefit of these individuals are not reimbursable under these guidelines, except where these individuals meet the criteria for intensive in-home treatment (e.g., they are 20 years of age or under) and authorization has been received for such services under these guidelines. For instance, intervention directed solely at a parent's alcohol abuse is considered substance abuse treatment, is covered as a substance abuse treatment service, and is not reimbursable in the home. However, when the intervention is with the whole family and is focusing on the way in which the parent's alcohol abuse is affecting the child and/or contributing to the problem behaviors, an in-home intervention may be authorized under these guidelines.

Initial treatment goals may include assessment of the member and family in the home and these goals may be procedural (e.g., complete assessment, have all members of family attend 75 percent of meetings, complete substance abuse assessment). Where an assessment is part of the initial intervention, be specific and detailed as to the components of the assessment (e.g., psychiatrist will complete psychiatric evaluation, substance abuse counselor will complete substance abuse assessment). Where appropriate, identify any standardized assessment tools that will be utilized.

If an in-home mental health/substance abuse treatment plan other than the model plan is used, all information on the model must be included.

f. Providers are required to complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale. Information about these screening instruments is available on the Internet under “Achenbach Behavior Checklist” and “Child and Adolescent Functional Assessment Scale.”

g. A substance abuse assessment must be included if substance abuse-related programming is part of the member’s treatment program. The assessment may be summarized in Element 14 as part of the psychiatric assessment or illness history.

The PA/ITA must be signed and dated by the certified psychotherapy/substance abuse treatment provider who is leading the in-home treatment team. It must also be signed and dated by the supervising therapist if the certified psychotherapy/substance abuse provider is not a Ph.D. psychologist or psychiatrist. In signing, these individuals accept responsibility for supervising the other individuals who are part of the in-home treatment team. In signing, they provide assurance that an individual who meets the criteria for a Medicaid-certified psychotherapy/substance abuse treatment provider will be available to the other team members when they are in the home alone with the child/family.

Element 21 — Signature — Certified Therapist
Enter the signature of the certified therapist.

Element 22 — Date Signed
Enter the month, day, and year the PA/ITA was signed (in MM/DD/CCYY format).

Element 23 — Signature — Supervising Therapist
Enter the signature of the supervising therapist.

Element 24 — Date Signed
Enter the month, day, and year the PA/ITA was signed (in MM/DD/CCYY format).

ATTACHMENT 8
Prior Authorization/In-Home Treatment Attachment (PA/ITA) (for photocopying)

(A copy of the "Prior Authorization/In-Home Treatment Attachment [PA/ITA]" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION / IN-HOME TREATMENT ATTACHMENT (PA/ITA)

Providers may submit prior authorization (PA) requests to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/In-Home Treatment Attachment (PA/ITA) Completion Instructions, F-11036A.

CHECK ONE ❑ **Initial PA Request** ❑ **First Reauthorization** ❑ **Subsequent Reauthorization**

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Age — Member
3. Member Identification Number	

SECTION II — PROVIDER INFORMATION

4. Name — Medicaid-Certified Clinic	5. Clinic's National Provider Identifier (NPI)
6. Name — Rendering Psychotherapist / Substance Abuse Counselor	7. Rendering Psychotherapist's / Substance Abuse Counselor's NPI
8. Telephone Number — Psychotherapist / Substance Abuse Counselor	9. Discipline — Psychotherapist / Substance Abuse Counselor

SECTION III

10. Enter the requested start and end dates for this authorization request. On the initial PA request, if backdating is needed, it must be requested in writing, and the clinical rationale for starting services before authorization is obtained must be documented.

11. Enter the number of hours of treatment to be provided to the family over this PA grant period. Providers should indicate the anticipated pattern of treatment by provider (e.g., a two-hour session once a week by certified therapist, a two-hour session once a week by the second team member with a certified therapist, plus a one-hour session twice a week by the second team member independently).

Continued

SECTION III (Continued)

12. Indicate the following for the period covered by this request.

- The number of hours the certified psychotherapy / substance abuse counselor will provide treatment _____
- The number of hours the second team member will provide treatment _____
- The name and credentials of the second team member. Include his or her degree and the number of hours of supervised clinical work he or she has done with severe emotional disturbance (SED) children in the space provided (attach résumé, if available).

13. Indicate the travel time for the period covered by this request.

Certified Psychotherapist / Substance Abuse Counselor		**Second Team Member**	
Anticipated Number of Visits	_____	Anticipated Number of Visits	_____
Travel Time per Visit	x_____	Travel Time per Visit	x_____
=	_____	=	_____

SECTION IV

Note: The following additional information must be provided. If attaching copies of existing records to provide the information requested, limit attachments to two pages for the psychiatric evaluation and illness / treatment history. Highlighting relevant information is helpful. Do not attach M-team summaries, additional social service reports, court reports, or other similar documents unless directed to do so following initial review of the documentation.

14. Present a summary of the member's current psychiatric assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or for children to age four, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3),* are required. The summary must present the signs and symptoms present in the member that meet criteria for the given DSM or DC:0-3 diagnosis. The summary does not include the history of the child's illness; this history should be provided in Element 15. A psychiatrist or a Ph.D. psychologist* must review and sign the summary and diagnoses.

Continued

SECTION IV (Continued)

15. Present a summary of the member's illness, treatment, and medication history. Include all significant background information. Describe the potential for change. Indicate if the child is currently in out-of-home placement, and, if so, the timeline for family reunification.

Continued

SECTION IV (Continued)

16. Complete the checklist to determine whether an individual meets the criteria for SED. Criteria for meeting the functional symptoms and impairments are found in the instructions. The disability must be evidenced by a, b, c, and d listed below.

a. A primary psychiatric diagnosis of mental illness or SED. Document diagnosis using the most recent version of the DSM or DC:0-3.

❑ _____

Primary Diagnosis

b. The individual must meet all three of the following.
- ❑ Be under the age of 21.
- ❑ Have emotional and behavioral problems that are severe in nature.
- ❑ This disability is expected to persist for a year or longer.

c. Symptoms and functional impairments
The individual must have one or two of the following.

1. Symptoms (must have one)
   - ❑ Psychotic symptoms.
   - ❑ Suicidality.
   - ❑ Violence.
2. Functional impairments (must have two)
   - ❑ Functioning in self care.
   - ❑ Functioning in the community.
   - ❑ Functioning in social relationships.
   - ❑ Functioning in the family.
   - ❑ Functioning at school / work.

d. The individual is receiving services from two or more of the following service systems.
- ❑ Mental Health.
- ❑ Social Services.
- ❑ Child Protective Services.
- ❑ Juvenile Justice.
- ❑ Special Education.

Enrollment criteria may be waived under the following circumstances.

- ❑ The member substantially meets the criteria for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning, but would likely do so without in-home mental health and substance abuse treatment services. Attach an explanation.
- ❑ The member substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

17. Present an assessment of the family's strengths and weaknesses.

Continued

SECTION IV (Continued)

18. Indicate the rationale for in-home treatment. Elaborate on this choice where prior outpatient treatment is absent or limited.

19. Indicate the expected date for termination of in-home treatment. Describe anticipated service needs following completion of in-home treatment and transition plans.

SECTION V

20. Attach and label all of the following.

    a. The Prior Authorization / Request Form (PA/RF), F-11018.
    b. A copy of a physician's prescription / order for in-home treatment services dated not more than one year prior to the requested first date of service (DOS).
    c. Documentation that the member had a comprehensive HealthCheck screening performed by a valid HealthCheck screener dated not more than one year prior to the first DOS. A copy of this documentation must be attached to all requests for reauthorizations (a copy of the original documentation may be used). **The initial request for these services must be received by ForwardHealth within one year of the date of the HealthCheck screening.**
    d. A multi-agency treatment plan.
    e. An in-home psychotherapy treatment plan.
    f. Results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS).
    g. A substance abuse assessment may be included. A substance abuse assessment **must** be included if substance abuse-related programming is part of the member's treatment program.

I attest to the accuracy of the information on this PA request. I understand that I am responsible for the supervision of the other team member(s) identified on this attachment. I, or someone with comparable qualifications, will be available to the other team member(s) at all times when he or she is in the home alone working with the child / family.

21. **SIGNATURE —** Certified Psychotherapist / Substance Abuse Counselor	22. Date Signed
23. **SIGNATURE —** Supervising Psychiatrist or Ph.D. Psychologist	24. Date Signed

* One who is licensed in Wisconsin and is listed, or is eligible to be listed, in the national register of health care providers in psychology.

ATTACHMENT 9
Model Plan: In-Home Mental Health/Substance Abuse Treatment Services (for photocopying)

(A copy of the "Model Plan: In-Home Mental Health/Substance Abuse Treatment Services" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11105 (10/08)

STATE OF WISCONSIN

FORWARDHEALTH

MODEL PLAN: IN-HOME MENTAL HEALTH / SUBSTANCE ABUSE TREATMENT SERVICES

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Name — Member	List agency team members developing and implementing this plan (include title indicating discipline).
Birth Date — Member	1.
Member Identification Number	2.
Date of This Plan	3.
Plan Review Date	4.
Name — Case Manager	5.
List family members involved in treatment.	6.
1.	7.
2.	8.
3.	
4.	
5.	
6.	

Problem 1	Short-Term Goal (Measurable)
Description of the Problem	Long-Term Goal (Measurable)
	Plan (Include the Frequency of Intervention and the Team Member[s] Responsible)
	Measurable Results of the Intervention at the Time of Plan Review

Problem 2	Short-Term Goal (Measurable)
Description of the Problem	Long-Term Goal (Measurable)
	Plan (Include the Frequency of Intervention and the Team Member[s] Responsible)
	Measurable Results of the Intervention at the Time of Plan Review

Problem 3	Short-Term Goal (Measurable)
Description of the Problem	Long-Term Goal (Measurable)
	Plan (Include the Frequency of Intervention and the Team Member[s] Responsible)
	Measurable Results of the Intervention at the Time of Plan Review

Problem 4	Short-Term Goal (Measurable)
Description of the Problem	Long-Term Goal (Measurable)
	Plan (Include the Frequency of Intervention and the Team Member[s] Responsible)
	Measurable Results of the Intervention at the Time of Plan Review

Problem 5	Short-Term Goal (Measurable)
Description of the Problem	Long-Term Goal (Measurable)
	Plan (Include the Frequency of Intervention and the Team Member[s] Responsible)
	Measurable Results of the Intervention at the Time of Plan Review

Program Discharge Criteria

SIGNATURE — Certified Psychotherapist/Substance Abuse Counselor	Date Signed
SIGNATURE — Psychologist/Psychiatrist *	Date Signed

* Either the in-home or multi-agency plan must be signed by a psychologist or psychiatrist.

ATTACHMENT 10
Model Multi-Agency Treatment Plan
(for photocopying)

(A copy of the "Model Multi-Agency Treatment Plan" is located on the following pages.)

FORWARDHEALTH

MODEL MULTI – AGENCY TREATMENT PLAN

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Name — Member	List agency team members developing and implementing this plan (include title indicating discipline).
Birth Date — Member	1.
Member Identification Number	2.
Date of This Plan	3.
Plan Review Date	4.
Case Manager	5.
List family members involved in treatment.	6.
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.
	Was parent or primary caregiver present? ❑ Yes ❑ No

Problem Summary: In the space provided below, describe the problems of the child and the family. Specify the elements of the problem that are to be addressed in treatment.

Mental Health Agency Response	Short Term Goal (Measurable)
	Long Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Social Services Agency Response	Short-Term Goal (Measurable)
	Long-Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review.

School Agency Response	Short-Term Goal (Measurable)
	Long-Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Juvenile Justice Agency Response	Short-Term Goal (Measurable)
	Long-Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Health Agency Response	Short Term Goal (Measurable)
	Long Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Services Recommended by the Treatment Plan

1.
2.
3.
4.
5.
6.

Program Discharge Criteria

SIGNATURE — Certified Psychotherapist / Substance Abuse Counselor	Date Signed
SIGNATURE — Psychologist / Psychiatrist*	Date Signed

I (we) have read the foregoing treatment plan and give my (our) consent for my (our) child to receive the treatment outlined above. I (we) will agree to participate in the treatment intervention outlined above.

SIGNATURE — Parent(s) or Primary Caregiver	Date Signed

* Either the in-home or multi-agency plan must be signed by a psychologist or psychiatrist.